ALLERGY ACTION PLAN

STUDENT'S NAME : _____ TEACHER :_____
GRADE _____ BUS RIDER ? _____ BUS NUMBER : _____

ALLERGIC TO :_____

Asthma : YES____ (if yes, higher risk for severe reaction) **NO_____**

➤➤STEP 1: TREATMENT

Symptoms:	**Give Checked Medication** **(to be determined by MD completing this plan)**
□ If allergen has been ingested, but *no symptoms:*	☐ Epinephrine ☐ Antihistamine
□ Mouth : Itching, tingling or swelling of lips, tongue, mouth	☐ Epinephrine ☐ Antihistamine
□ Skin : Hives, itchy rash, swelling of face or extremities	☐ Epinephrine ☐ Antihistamine
□ Gut : Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine
□ Throat : Tightening of throat, hoarseness, hacking cough✤	☐ Epinephrine ☐ Antihistamine
□ Lung : Shortness of breath, repetitive coughing, wheezing✤	☐ Epinephrine ☐ Antihistamine
□ Heart : Weak pulse, low blood pressure, fainting, pale, blue✤	☐ Epinephrine ☐ Antihistamine
□ Other :_____	☐ Epinephrine ☐ Antihistamine
□ If reaction is progressing (several of the above areas affected), give	☐ Epinephrine ☐ Antihistamine

✤Potentially life threatening. Note that severity of symptoms can quickly change.

DOSAGE
Epinephrine : inject intramuscularly _____
Antihistamine : give_____

➤➤STEP 2: EMERGENCY CALLS

1) **Call 911 !** State that an allergic reaction has been treated and additional epinephrine may be needed.
2) Emergency contacts : Name_____Ph #_____
   Name_____Ph #_____

EVEN IF PARENTS CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR CALL 911.
Parent Signature_____Date_____
Doctor's Signature_____ Date_____